Choices for Care - Home-Based Setting

Assistive Devices and Home Modifications Form

Individual Name: _____

1) Check One:

☐ **Assistive Device:** *Definition* - An item, piece of equipment, or product that is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability.

☐ **Home Modification:** *Definition* - Physical adaptation to the home which is necessary to allow safe access to and use of, the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home.

2) Cost of device/modification: $_____ (*maximum $750 per calendar year*)

3) Assistive Devices/Home Modifications $ spent to date in current calendar year (*not including this request*):
$_____

4) Description of Device/Modification: _____
_____
_____

5) Justification for Request: _____
_____
_____

6) Recommended by (check all that apply): ☐physician, ☐PT/OT, ☐RN, ☐Other_____

7) Is the device or modification on the "Pre-approved" list of items located on the back?
☐Yes ☐No - DAIL "prior-authorization" required.

By submitting and signing this form, the Case Manager assures the following:

- No other payer: The assistive devices or home modifications are not otherwise available to the individual through Medicare, Medicaid, or other private insurance coverage.
- Effectiveness: Consultants (such as physical therapists, occupational therapists, Assistive Technology Project staff) have been used, if necessary, to properly identify individual needs for assistive devices and home modifications, and to assist in the development of an effective service plan.
- Choices for Care standards: Applicable Choices for Care standards and procedures have been followed in developing this request.

Case Manager's signature: _____ Date: _____

For items requiring "prior-authorization", DAIL will make a determination and return with "approved" or "denied". A copy of the request must be maintained by the case management agency as billing authorization. *See back for more information.*

For Official Use Only – Items requiring "prior-authorization"

The above request is: ☐Approved OR ☐Denied – reason described below, see attached notice for appeal rights.

Reason for denial: _____
_____
_____

DAIL Authorized Signature: _____ Date: _____

-Mail form to regional DAIL office-

Pre-Approved Items:

The Department of Disabilities, Aging and Independent Living (DAIL) has pre-approved the following items for individuals who require Assistive Devices or Home Modifications according to the service definitions. The case manager must submit this form to the DAIL regional office identifying the item or modification being purchased. The case management agency may purchase the item immediately and submit for reimbursement upon completion of this form. Total purchases may not exceed **$750 per calendar year** per individual.

1. Adaptive eating utensils
2. Adaptive kitchen utensils
3. Adaptive sinks/faucets
4. Adaptive telephones with large numbers
5. Air conditioner: for individuals with Chronic Obstructive Pulmonary Disease (COPD) ***only***
6. Bath/shower chair: with or without transfer bench *(for individuals with dual Medicare/Medicaid coverage **only**)*
7. Bed rails/U-bar: for the purpose of transferring and/or bed mobility ***only***, **NOT** to be used as a restraint
8. Doorways widened for accessibility to bedroom, bathroom, kitchen, primary living space, or primary exit/entrance
9. Dressing aides
10. Gait belt for mobility and transfers
11. Grab bars/"Super pole"
12. Hand held shower unit
13. Medication reminder units
14. Raised toilet seat *(for individuals with dual Medicare/Medicaid coverage **only**)*
15. Ramp for primary entrance/exit
16. Reacher/grabber
17. Repairs or modifications to items on this list
18. Roll-in or other modified bath/shower unit
19. Seat lift chairs for the purpose of transferring: purchase of the chair ***only*** after Medicare/Medicaid pays for lift mechanism *(for individuals with dual Medicare/Medicaid coverage **only**)*
20. Shampoo tray for bed-bath
21. Walker wheels
22. Wander devices - for individuals with dementia ***only***

Prior Authorization Requests:

Items that do not appear on the above "pre-approved" list must obtain "prior-authorization" from DAIL. Determinations will be made based on the individual's unique circumstances as they apply to the current service definitions, policies and regulations. An insurance denial letter must be sent to DAIL with requests for items generally covered by Medicare, Medicaid, or private insurance. The case management agency may purchase the item and submit for reimbursement only after return receipt of the DAIL approved request. ***Refer to the "Assistive Devices & Home Modifications" section of the Choices for Care Operational Protocol Manual for detailed information and a list of "non-covered" items.***

-Mail form to regional DAIL office-